HealthierHere

Clinical Summary
Chronic Disease Management: Diabetes

Goal

Immediate: Identify individuals with diabetes, stratify risk level, and improve care coordination for highest risk individuals.

Long-term: Decrease rates of diabetes-related complications in those with the disease. Empower individuals with diabetes to implement successful self-management practices.

Focus Population

Medicaid members age 18 and older with an ICD-10 code on the problem list diagnosing type 1 or type 2 diabetes. Individuals with diabetes are considered at high risk for complications with one or more of the following: HbA1c >9%, blood pressure ≥140/90, history of cardiovascular disease, one or more emergency department visits in past 12 months related to diabetes, and history of smoking/tobacco use.

Key Project Elements

The following interventions are recommended for participating provider organizations. Pursuing the recommended strategies as appropriate for specific focus populations is likely to help Practice Partners achieve their goals related to HealthierHere's 2019 pay for progress incentives.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the Chronic Care Model and the American Diabetes Association Standards of Medical Care in Diabetes recommendations, implementing organizations are encouraged to utilize the following key strategies.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers, behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Ensure that registry is in place to allow for identification of target population, and establish a process to for adding appropriate individuals to registry (e.g., individuals who have diabetes without a corresponding ICD-10 code on the problem list).
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Identify and risk stratify individuals with type 1 or type 2 diabetes.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a registered dietician, social worker, or other appropriate provider.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Ensure each member of the focus population has a planned diabetes visit in which their glycemic control, cardiovascular risk factors, and end-organ damage are assessed. This assessment should also include behavioral health, oral health, and social determinants of health.
- Refer individual to community support specialist (e.g., community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally relevant treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- Provide all individuals with diabetes with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals at highest risk for complications from diabetes to a community support specialist (e.g., community health worker, peer educator, or health coach) who will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
    a. Increase self-management skills
    b. Ensure personal goals are congruent with individual's self-efficacy
    c. Improve continuity of care with primary care follow-up
    d. Ensure medication management and reconciliation with primary care or other providers including pharmacists
    e. Practice advocacy by identifying key questions for primary care providers/specialists
    f. Educate on health system navigation
    g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why.

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services and/or chronic disease self-management programs.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g., transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and a community support specialist to support selected activities. In such cases, the community support specialist will communicate with primary care providers and/or specialist(s) regarding the individual's treatment and progress.

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Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Chronic Disease Management – Diabetes project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
Comprehensive Diabetes Care: Hemoglobin A1c Testing	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year.
Comprehensive Diabetes Care: Medical Attention for Nephropathy	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement period.
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional during the measurement period, or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.

References/Guidelines

American Diabetes Association Standards of Medical Care in Diabetes – 2018 Abridged for Primary Care Providers
http://clinical.diabetesjournals.org/content/early/2017/12/07/cd17-0119

The Chronic Care Model
http://www.improvingchroniccare.org/

Diabetes Self-Management Program
https://www.selfmanagementresource.com/programs/small-group/diabetes-self-management/

Practice Transformation for Physicians and Health Care Teams
https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/practice-transformation-physicians-health-care-teams

Self-Management Resource Center
https://www.selfmanagementresource.com/